DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 — 0 0 6

2. STATE: Nebraska

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ Ø
b. FFY 2001 $ Ø

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Att: 3.1A, Att: 4.19B

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Att: 3.1A, Att: 4.19B

10. SUBJECT OF AMENDMENT:
Telehealth

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Robert J. Seiffert

13. TYPED NAME:
Robert J. Seiffert

14. TITLE:
Medicaid Administrator

15. DATE SUBMITTED: 25
August 30, 2000

16. RETURN TO:
HHS F&S
Medicaid Division
Attn: Dana McNeil
P.O.Box 95026
Lincoln, NE 68509-5026

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
08/29/00

18. DATE APPROVED:
MAR 16 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 1 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Thomas W. Lenz

22. TITLE:
ARA for Medicaid and State Operations

23. REMARKS:

cc:
Raymond
Seiffert
CO

SPA CONTROL

Date Submitted 08/28/00
Date Received 08/29/00

FORM HCFA-179 (07-92)

Instructions on Back

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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1. Inpatient hospital services other than those provided in an institution for mental diseases.

   Provided: ___ No limitations X With limitations*

2.a. Outpatient hospital services.

   Provided: ___ No limitations X With limitations*

   b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State Plan)

   X Provided: ___ No limitations X With limitations*

   ___ Not provided.

   c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with sec. 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

   Provided: ___ No limitations X With limitations*

3. Other laboratory and x-ray services.

   Provided: ___ No limitations X With limitations*

*Description provided on attachment

State/Territory: Nebraska

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: ___ No limitations __X__ With limitations*

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

Provided: ___ No limitations __X__ With limitations

c. Family planning services and supplies for individuals of child-bearing age.

Provided: ____ No limitations __X__ With limitations*

5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided: ____ No limitations __X__ With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the act).

Provided: ___ No limitations __X__ With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by state law.

a. Podiatrists' services.

Provided: ___ No limitations __X__ With limitations*

* Description provided on attachment.

State/Territory: Nebraska

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

__X__ Provided: ____ No limitations __X__ With limitations*

____ Not provided.

c. Chiropractors' services.

__X__ Provided: ____ No limitations __X__ With limitations*

____ Not provided.

d. Other practitioners' services.

__X__ Provided: Identified on attached sheet with description of limitations.

____ Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

__X__ Provided: ___ No limitations __X__ With limitations*

b. Home health aide services provided by a home health agency.

__X__ Provided: ___ No limitations __X__ With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

__X__ Provided: ____ No limitations __X__ With limitations*

*Description provided on attachment.

State/Territory: Nebraska

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

_X_ Provided: ___ No limitations _X_ With limitations*

___ Not provided.

8. Private duty nursing services.

_X_ Provided: ___ No limitations _X_ With limitations*

____ Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

X Provided: ___ No limitations X With limitations*

___ Not provided.

10. Dental services.

X Provided: ___ No limitations X With limitations*

___ Not provided.

11. Physical therapy and related services.

a. Physical therapy.

X Provided: ___ No limitations X With limitations*

___ Not provided.

b. Occupational therapy.

X Provided: ___ No limitations X With limitations*

___ Not provided.

c. Services for individuals with speech, hearing. and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

X Provided: ___ No limitations X With limitations*

___ Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Proscribed drugs. dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

_X_ Provided: ___ No limitations _X_ With limitations*

___ Not provided.

b. Dentures.

_X_ Provided: ___ No limitations _X_ With limitations*

___ Not provided.

c. Prosthetic devices.

_X_ Provided: ___ No limitations _X_ With limitations*

___ Not provided.

d. Eyeglasses.

_X_ Provided: ___ No limitations _X_ With limitations*

___ Not provided.

13. Other diagnostic. screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

___ Provided: ___ No limitations ___ With limitations*

_X_ Not provided.

*Description provided on attachment.

AMOUNT, DURATION. AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.

X Provided: ___ No limitations X With limitations*

___ Not provided.

c. Preventive services.

___ Provided: ___ No limitations ___ With limitations*

X Not provided.

d. Rehabilitative services.

X Provided: ___ No limitations X With limitations*

___ Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

X Provided: ___ No limitations X With limitations*

___ Not provided.

b. Skilled nursing facility services.

X Provided: ___ No limitations X With limitations*

___ Not provided.

c. Intermediate care facility services.

X Provided: ___ No limitations X With limitations*

___ Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15.a. Intermediate care facility services (other than such services in an institution for mental disease) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

_X_ Provided: ___ No limitations _X_ With limitations:

___ Not provided.

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

_X_ Provided: ___ No limitations _X_ With limitations:

___ Not provided.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

_X_ Provided: ___ No limitations _X_ With limitations:

___ Not provided.

17. Nurse-midwife services;

_X_ Provided: ___ No limitations _X_ With limitations:

___ Not provided.

18. Hospice care (in accordance with section 1905(o) of the Act).

___ Provided ___ No limitations ___ With limitations:

_X_ Not provided.

Transmittal # MS-00-06

Supersedes Approval Date MAR 16 2001 Effective Date JUL 1 2000

Transmittal # MS-95-13

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3..1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

_X_ Provided: _X_ With limitations

___ Not provided.

b. Special tuberculosis (TB) related services under section 1902 (z) (2) (F) of the Act.

___ Provided: ___ With limitations*

_X_ Not provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

___ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

___ Additional coverage ++

Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

X Provided: ___ No limitations X With limitations*

___ Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

___ Provided: ___ No limitations ___ With limitations*

X Not provided.

23. Certified pediatric or family nurse practitioners' services.

Provided: ___ No limitations X With limitations*

*Description provided on attachment

State/Territory: Nebraska

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

X Provided: ___ No limitations X With limitations*

___ Not provided.

b. Services of Christian Science nurses.

___ Provided: ___ No limitations ___ With limitations*

X Not provided.

c. Care and services provided in Christian Science sanitoria.

___ Provided: ___ No limitations ___ With limitations*

X Not provided.

d. Nursing facility services for patients under 21 years of age.

X Provided: ___ No limitations X With limitations*

___ Not provided.

e. Emergency hospital services.

X Provided: ___ No limitations X With limitations*

___ Not provided.

State: Nebraska

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

X Provided ____ Not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

X Provided:
___ State Approved (Not Physician) Service Plan Allowed
___ Services Outside the Home Also Allowed
X Limitations Described on Attachment

___ Not Provided.

Telehealth Service means any contact between a patient and a health care practitioner relating to health care diagnosis or treatment of such patient through telehealth but does not include a telephone conversation, electronic mail message, or facsimile transmission between a health care practitioner and a patient or a consultation between two health care providers.

Health care practitioners must:

1. act within their scope of practice;
2. be enrolled with NMAP; and
3. be appropriately licensed, certified, or registered by Nebraska HHS Regulation and Licensure for the service for which they bill Medicaid.

All state plan prior authorization requirements must be met to be covered as a telehealth service. Prior authorization requests must state the intent to provide the service as a telehealth service.

Medicaid services covered under the State Plan but specifically excluded from telehealth coverage are:

1. Medical equipment and supplies provided by DME (Durable Medical Equipment) suppliers and pharmacies;
2. Orthotics and prosthetics provided by DME suppliers and pharmacies;
3. Personal Care Aide (PCA) services;
4. Home Health Aide services;
5. Pharmacy services for prescribed drugs;
6. Home and Community Based Waiver services provided by persons that do not meet the standards for practitioner of telehealth services;
7. Mental health, substance abuse, and psychiatric rehabilitation services provided by persons that do not meet the standards for practitioner of telehealth services;
8. Medical transportation services, including ambulance services;
9. Federally Qualified Health Center core services billed as an "encounter" service;
10. Rural Health Clinic core services billed as an "encounter" service;
11. Physician visits to clients in nursing facilities required on the specific periodic schedule for nursing facility certification;
12. Tribal 638 clinic core services billed as an "encounter" service;
13. Services requiring "hands on" professional services such as eye glass fittings and hearing aid fittings;
14. Services provided in public schools by staff who are not licensed, certified, or registered with Nebraska HHS - Regulation and Licensure; and
15. Ambulatory room and board services.

Services provided via telecommunications are not covered if the client has access to a comparable service within 30 miles of his/her place of residence.

This requirement does not apply:

1. In emergency or urgent medical situations;
2. When accessing the appropriate service at a distance less than 30 miles poses a significant hardship on the client due to a medical condition or disability; or
3. To clients residing in nursing facilities who require transportation to the appropriate service via ambulance.

A telehealth service is not covered when the service delivered via telecommunication technology is deemed to be investigational or experimental. Even though a service is covered when provided in-person to a client, the service may be deemed investigational/experimental for Medicaid payment purposes when provided via telecommunications technology.

Transmission costs are not covered when the telehealth service provided by the health care practitioner is not a covered state plan service.

Services that require direct physical contact with a client by a health care practitioner and that cannot be delegated to another health care practitioner at the site where the client is located are not covered.

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All groups

1. Inpatient hospital services other than those provided in an institution for mental diseases.

X Provided: ___ No limitations X With limitations*

2.a. Outpatient hospital services.

X Provided: ___ No limitations X With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State Plan)

X Provided: ___ No limitations X With limitations*

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with sec. 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

X Provided: ___ No limitations X With limitations*

3. Other laboratory and x-ray services.

X Provided: ___ No limitations X With limitations*

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

X Provided: ___ No limitations X With limitations*

b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

X Provided: ___ No limitations X With limitations

c. Family planning services and supplies for individuals of child-bearing age.

X Provided: ___ No limitation X With limitations*

*Description provided on attachment

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All groups

5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided: ____ No limitations X With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the act).

Provided: ____ No limitation X With limitations*

* Description provided on attachment.

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All covered groups

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6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by state law.

a. Podiatrists' services.

X Provided: ____ No limitations X With limitations*

b. Optometrists' services.

X Provided: ____ No limitations X With limitations*

c. Chiropractors' services.

X Provided: ____ No limitations X With limitations*

d. Other practitioners' services.

X Provided: ____ No limitations X With limitations*

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

X Provided: ___ No limitations X With limitations*

b. Home health aide services provided by a home health agency.

X Provided: ___ No limitations X With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

X Provided: ____ No limitations X With limitations*

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

X Provided: ___ No limitations X With limitations*

*Description provided on attachment.

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All covered groups

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8. Private duty nursing services.

X Provided: ___ No limitations X With limitations*

9. Clinic services.

X Provided: ___ No limitations X With limitations*

10. Dental services.

X Provided: ___ No limitations X With limitations*

11. Physical therapy and related services.

a. Physical therapy.

X Provided: ___ No limitations X With limitations*

b. Occupational therapy.

X Provided: ___ No limitations X With limitations*

c. Services for individuals with speech, hearing. and language disorders provided by or under the supervision of a speech pathologist or audiologist.

X Provided: ___ No limitations X With limitations*

12. Prescribed drugs. dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

X Provided: ___ No limitations X With limitations*

b. Dentures.

X Provided: ___ No limitations X With limitations*

Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All covered groups

c. Prosthetic devices.

X Provided: ___ No limitations X With limitations*

d. Eyeglasses.

X Provided: ___ No limitations X With limitations*

13. Other diagnostic. screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

___ Provided: ___ No limitations ___ With limitations*

X Not provided.

b. Screening services.

X Provided: ___ No limitations X With limitations*

c. Preventive services.

___ Provided: ___ No limitations ___ With limitations*

X Not provided.

d. Rehabilitative services.

X Provided: ___ No limitations X With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

X Provided: ___ No limitations X With limitations*

b. Skilled nursing facility services.

X Provided: ___ No limitations X With limitations*

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All covered groups

c. Intermediate care facility services.

X Provided: ___ No limitations X With limitations*

15.a. Intermediate care facility services (other than such services in an institution for mental disease) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

X Provided: ___ No limitations X With limitations:

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

X Provided: ___ No limitations X With limitations:

16. Inpatient psychiatric facility services for individuals under 22 years of age.

X Provided: ___ No limitations X With limitations:

17. Nurse-midwife services;

X Provided: ___ No limitations X With limitations:

18. Hospice care (in accordance with section 1905(o) of the Act).

___ Provided ___ No limitations ___ With limitations:

X Not provided.

Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All covered groups

19. Case management services and Tuberculosis related services

a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3..1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

X Provided: X With limitations

___ Not provided.

b. Special tuberculosis (TB) related services under section 1902 (z) (2) (F) of the Act.

___ Provided: ___ With limitations*

X Not provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

X Provided: ___ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

X Provided: ___ Additional coverage ++ X Not provided.

Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

X Provided: ___ No limitations X With limitations*

___ Not provided.

*Description provided on attachment.

State: Nebraska

Major Categories of Services That Are Available As
Pregnancy-Related services or Services For Any
Other Condition That May Complicate Pregnancy

The Nebraska Medical Assistance Program covers the following major categories of services as pregnancy-related services or services for a condition that may complicate pregnancy:

1. All services covered under the Title XIX Plan are available when pregnancy-related or for a condition that may complicate pregnancy; and
2. The same limitations listed in Attachment 3.1-A are applied to pregnancy-related services or services for a condition that may complicate pregnancy.

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All groups

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

___ Provided: ___ No limitations ___ With limitations*

_X_ Not provided.

23. Certified pediatric or family nurse practitioners' services.

_X_ Provided: ___ No limitations _X_ With limitations*

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

_X_ Provided: ___ No limitations _X_ With limitations*

b. Services of Christian Science nurses.

___ Provided: ___ No limitations ___ With limitations*

_X_ Not provided.

c. Care and services provided in Christian Science sanitoria.

___ Provided: ___ No limitations ___ With limitations*

_X_ Not provided.

d. Nursing facility services for patients under 21 years of age.

_X_ Provided: ___ No limitations _X_ With limitations*

e. Emergency hospital services.

_X_ Provided: ___ No limitations _X_ With limitations*

*Description provided on attachment

State: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All groups

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

X Provided ____ not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

X Provided:
___ State Approved (Not Physician) Service Plan Allowed
___ Services Outside the Home Also Allowed
X Limitations Described on Attachment

___ Not Provided.

2/14/01

Telehealth Service means any contact between a patient and a health care practitioner relating to health care diagnosis or treatment of such patient through telehealth but does not include a telephone conversation, electronic mail message, or facsimile transmission between a health care practitioner and a patient or a consultation between two health care providers.

Health care practitioners must:

1. act within their scope of practice;
2. be enrolled with NMAP; and
3. be appropriately licensed, certified, or registered by Nebraska HHS Regulation and Licensure for the service for which they bill Medicaid.

All state plan prior authorization requirements must be met to be covered as a telehealth service. Prior authorization requests must state the intent to provide the service as a telehealth service.

Medicaid services covered under the State Plan but specifically excluded from telehealth coverage are:

1. Medical equipment and supplies provided by DME (Durable Medical Equipment) suppliers and pharmacies;
2. Orthotics and prosthetics provided by DME suppliers and pharmacies;
3. Personal Care Aide (PCA) services;
4. Home Health Aide services;
5. Pharmacy services for prescribed drugs;
6. Home and Community Based Waiver services provided by persons that do not meet the standards for practitioner of telehealth services;
7. Mental health, substance abuse, and psychiatric rehabilitation services provided by persons that do not meet the standards for practitioner of telehealth services;
8. Medical transportation services, including ambulance services;
9. Federally Qualified Health Center core services billed as an "encounter" service;
10. Rural Health Clinic core services billed as an "encounter" service;
11. Physician visits to clients in nursing facilities required on the specific periodic schedule for nursing facility certification;
12. Tribal 638 clinic core services billed as an "encounter" service;
13. Services requiring "hands on" professional services such as eye glass fittings and hearing aid fittings;
14. Services provided in public schools by staff who are not licensed, certified, or registered with Nebraska HHS - Regulation and Licensure; and
15. Ambulatory room and board services.

Services provided via telecommunications are not covered if the client has access to a comparable service within 30 miles of his/her place of residence.

This requirement does not apply:

1. In emergency or urgent medical situations;
2. When accessing the appropriate service at a distance less than 30 miles poses a significant hardship on the client due to a medical condition or disability; or
3. To clients residing in nursing facilities who require transportation to the appropriate service via ambulance.

A telehealth service is not covered when the service delivered via telecommunication technology is deemed to be investigational or experimental. Even though a service is covered when provided in-person to a client, the service may be deemed investigational/experimental for Medicaid payment purposes when provided via telecommunications technology.

Transmission costs are not covered when the telehealth service provided by the health care practitioner is not a covered state plan service.

Services that require direct physical contact with a client by a health care practitioner and that cannot be delegated to another health care practitioner at the site where the client is located are not covered.

ATTACHMENT 3.1-A
Item 1a
Applies to Both
Categorically and
Medically Needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - INPATIENT HOSPITAL SERVICES

Reimbursement for inpatient hospital care of patients whose primary care needs are psychiatric in nature are limited to a hospital or distinct part of a hospital that -

1. Is maintained for the care and treatment of patients with primary psychiatric disorders;
2. Is licensed or formally approved as a hospital by the Nebraska Department of Health and Human Services Regulation and Licensure, or if the hospital is located in another state, the officially designated authority for standard-setting in that state;
3. Is accreditated by the Joint Commission on Accreditation of Healthcare Organizations or American Osteopathic Association;
4. Meets the requirements for participation in Medicare for psychiatric hospitals; and
5. Has in effect a utilization review plan applicable to all Medicaid clients.

Transmittal # MS-00-06

Supercedes Approved MAR 16 2001 Effective JUL 1 2000

Transmittal # MS-95-13

ATTACHMENT 3.1-A
Item 1c
Applies to Both
Categorically and
Medically Needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - INPATIENT HOSPITAL SERVICES

NMAP covers medical transplants including donor services that are medically necessary and defined as non-experimental by Medicare. If no Medicare policy exists for a specific type of transplant, the appropriate staff in the Medicaid Division shall determine whether the transplant is medically necessary and non-experimental.

Notwithstanding any Medicare policy on liver or heart transplants, the Nebraska Medical Assistance Program covers liver or heart transplantation when the written opinions of two physicians specializing in transplantation state that -

1. No other therapeutic alternatives exist; and
2. The death of the patient is imminent.

NMAP requires prior authorization of all transplant services before the services are provided.

NMAP covers medically necessary services for the NMAP-eligible donor to an NMAP-eligible client. The services must be directly related to the transplant.

NMAP covers laboratory tests for NMAP-eligible prospective donors. The tests must be directly related to the transplant.

NMAP covers medically necessary services for the NMAP-ineligible donor to an NMAP-eligible client. The services must be directly related to the transplant and must directly benefit the NMAP transplant client. Coverage of treatment of complications is limited to those that are reasonably medically foreseeable.

NMAP covers laboratory tests for NMAP-ineligible prospective donors that directly benefit the NMAP transplant client. The tests must be directly related to the transplant.

NMAP does not cover services provided to an NMAP-ineligible donor that are not medically necessary or that are not directly related to the transplant.

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